

Executive Summary:

Comprehensive Health Care Reform for Colorado



“... All Americans need financial security and quality health care they can afford. ...The time is long overdue for America to address these problems. America needs a plan for the 21st century. Not a Democratic or Republican plan, or a business or labor plan. We need an American plan; a plan to insure that the American Dream endures for our children and grandchildren.”

*Andy Stern
President, SEIU International
January 16, 2007*

The nurses and working families of the Service Employees International Union (SEIU) and the Colorado Association of Public Employees (CAPE) believe that health care is the most serious economic and social concern facing Coloradans today and that comprehensive health care reform is needed now.

Approximately 770,000 Colorado residents lack health insurance.¹ Businesses – particularly small businesses – find it increasingly difficult to provide their employees with even the most basic of health care, jeopardizing the ability to remain competitive in the state, national and global marketplace. Many working families, unable to afford the skyrocketing cost of coverage, take a huge risk with their family’s health and financial future, hoping that they will simply not get sick – often paying for it with their savings, their homes and their lives. Those who qualify for public programs receive care that could be more cost-effective and better managed. With projections that Colorado’s elderly population will increase by a staggering 59% during the next 15 years,² we find ourselves inadequately prepared to address what can be the most expensive care of all – long term supports and services.

SEIU and CAPE believe we need health care reform that puts us on a real path to universal coverage and delivers innovative, new ways to address the health care challenges ahead. At the same time, we need a pragmatic path – one that allows us to meet these goals while taking into account the financial realities facing our state.

The SEIU and CAPE proposal is a comprehensive plan that will:

- Provide a path to universal health care coverage in Colorado.

¹ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

² Ari Houser, Wendy Fox-Grage and Mary Jo Gibson. “Across The States: Profiles of Long-Term Care and Independent Living. Colorado.” AARP Public Policy Institute. Dec. 2006.
http://assets.aarp.org/rgcenter/health/d18763_2006_atc_co.pdf

- Extend health care to low-income uninsured with Medicaid-funded premium subsidies to purchase insurance to protect and improve health.
- Ensure improved access to medically appropriate and cost-effective quality long term care services now and in the future.
- Promote greater access, choice, personal responsibility and affordability for working families through the creation of a Health Insurance Exchange.
- Help Colorado's small businesses purchase quality, affordable health plans for their employees.
- Ensure quality care and promote accountability in Colorado's health care facilities to protect patients.
- Create incentives for preventive care, wellness, health education, quality outcomes and consumer empowerment.
- Adopt best practices, evidence-based medicine, and pay for performance to improve health care delivery.
- Ensure stable and sustainable funding that is fair, viable and cost-effective.

Creating a Path to Universal Health Care Coverage

Of the 770,000 uninsured residents in Colorado, almost 75% are low-income children, parents and childless adults with incomes under 300% of the federal poverty level (FPL).³ Approximately 20% of working age adults is uninsured. Almost 30% of employees who work for very small businesses are uninsured, compared to 12% of those who work for very large businesses.⁴

This proposal would extend health insurance coverage to uninsured low-income populations and small businesses by creating a platform for universal access to health care for all Colorado residents. The plan would enable Colorado to take advantage of the current interest the federal government has in working with states to expand coverage. Recent changes in federal law and policy and innovative Medicaid-funded state health care reform initiatives across the country support comprehensive reform and could extend coverage to an estimated 96% of Colorado residents.⁵ While the proposed approach establishes the building blocks for further reform, implementation would be phased in to ensure a gradual transition to a more cost-effective delivery system with continued support for the State's critical safety net providers.

³ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

⁴ "Profile of the Uninsured in Colorado: An Update for 2005." Issue Brief, Colorado Health Institute. Nov. 2006. Pp. 2.

⁵ Calculation based upon data from the U.S. Census Bureau Survey and "Profile of the Uninsured in Colorado" issue brief.

Key cornerstones of the proposal include:

- **New Subsidy.** A new Medicaid-funded subsidy would be established for low-income uninsured to purchase primary care health insurance.
- **Low-Income/Safety Net Care Pool.** To support subsidies to low-income uninsured, a low-income pool would be funded by a consolidation of funds the state now expends for uncompensated care and health services to the uninsured, efficiencies in the current Medicaid program, and other revenues approved under an agreement with the federal government. Low-income residents would be eligible for a Medicaid-funded subsidy to purchase a private health plan. Likewise, small businesses that have not offered employee coverage for one year and that have higher-income workers would be able to purchase products without a subsidy.

Although Medicaid-funded subsidies up to 300% of the federal poverty level (FPL) could be provided if funding were available and the proposal is consistent with federal reform objectives, priority populations in the initial years could include:

- Children up to 300% of the federal poverty level (FPL);
 - Parents up to 250% of the FPL; and
 - Childless adults up to 225% of the FPL.
- **New Agreement with the Federal Government.** To maximize federal claiming, a new agreement would be negotiated as part of a Medicaid section 1115 waiver and related Medicaid State Plan Amendments. The financing for the necessary state match for the waiver would come primarily from funds already spent in Colorado on health care for the uninsured, including disproportionate share hospital (DSH) payments, unexpended federal SCHIP funds, and financing mechanisms approved by the federal government for comprehensive reform (unmatched state and local public funds spent for health care services).
 - **System to Ensure Access to Affordable Coverage.** Health care would be provided through private market insurance products offered by a Health Insurance Exchange to ensure a choice of affordable plans with options for individuals and families. The plan would provide premium assistance to low-income uninsured for the purchase of health insurance on a sliding scale, based on income, and individuals would be allowed to voluntarily opt out to enroll in employer-sponsored insurance, using their premium assistance to pay for any required employee contribution.

SEIU and CAPE believe this is a cost effective and realistic approach to expanding health care coverage in Colorado at the present time. We would, however, encourage the Legislature, the Commission and the Governor to work with the federal government to continue to expand coverage in the future until every Coloradan is guaranteed affordable health care.

Improving the Long Term Care System

In the next 15 years, the median age in Colorado is increasing. Colorado faces an aging population that threatens to overwhelm the programs that care for some of our state's most vulnerable residents and Colorado's ability to control skyrocketing health care costs. The AARP "Across the States Report" projects there will be a 59% increase in Colorado's 85-plus population and a 124% increase in our state's Alzheimer's population during the next 15 years.⁶

This proposal would balance Colorado's long term care system, putting a greater emphasis on home-and community-based care, which both meets the preferences and dignity of elderly residents (80 percent of the Colorado AARP members surveyed in 2005 said it is extremely or very important to have long term care services that enable them to stay at home as long as possible) and reduces their dependence on higher cost nursing home facilities.⁷

The proposal would ensure that all individuals will have the freedom to choose between long term care models, all of which would have strong and integrated care management to provide services in the least restrictive setting and most cost effective manner. This is consistent with and builds on the findings of the Long-Term Care Advisory Committee's July 2006 final report to the Colorado Department of Health Care Policy and Financing, which called for the delivery of services in a person-centered and consumer directed manner.⁸

Components of the proposal include:

- **Development of Special Needs Plans and Other Integrated Models.** The Deficit Reduction Act (DRA) established Special Needs Plans (SNPs) as a tool that could be used by Colorado to integrate Medicare and Medicaid primary, acute and long term care, prescription drugs, and behavioral health services for dual eligibles. The goal of SNPs is to meet the important 3 H's of long term care - keeping the individual healthy, happy and at home. This proposal will also

⁶ Houser, et al, Across the States.

⁷ Houser, et al, Across the States.

⁸ "Report of the Senate Bill 05-173 Long Term Care Advisory Committee." Submitted to the CO Department of Health Care Financing, July 1, 2006.

develop other integrated models that ensure access to well-coordinated and high quality long term care.

- **Consumer Directed Care.** Current enrollees, but especially baby boomers want more control of their health and support program. A CMS-sponsored study found that consumer directed care is less costly than other forms of home care and higher satisfaction rates may postpone nursing facility placements.⁹ Making consumer directed care more accessible is a central part of the plan to give consumers a fuller range of health care options.
- **Adjusting Eligibility and Utilization.** As noted in the Long-Term Care Advisory Committee report, long term care reimbursement should be used to encourage appropriate treatment in the least restrictive setting possible. This proposal lays out a number of incentives and disincentives to balance long term care, including right sizing incentives to create a higher quality and more home-like environment in nursing home facilities and the adoption of a tiered reimbursement for facilities that provide comprehensive health benefits. This proposal also recommends increasing the threshold for clinical placement into a nursing home facility to ensure that the most restrictive setting (institutional care) is reserved for those with the highest acuity levels.
- **Commitment to Affordable Housing as a Long Term Care Priority.** States that have attempted to transition individuals from nursing homes have found that one of the largest barriers is the difficulty in obtaining affordable housing for lower income seniors. This can be overcome through policy tools like housing set asides or priority placements and the integration of housing experts into the program.
- **Quality Management.** Initiatives to improve quality include establishing a LTC Quality Management Committee, benchmarks and performance standards, a quality management strategy, a formal backup system, a training program, and a public authority.
- **Staff Training.** In light of Colorado's significant projected increase in Alzheimer's disease over the next few years, there should be specific focus on specialized units, specialized training and consistency in staffing. Certified nursing assistants should be transitioned to providing assisted living and consumer directed care.
- **Cost Savings of Non-Institutional Care.** In addition to consumers preferring assisted living care over institutional care, such care tends to be less expensive than traditional nursing facilities, as shown below.

⁹ Kevin J. Mahoney and Kristin Simone. "History of and Lessons from the Cash and Counseling Demonstration and Evaluation." Scripps Gerontology Center, Robert Wood Johnson Foundation. July 6, 2006.

Based on Full Year	Nursing Facility	Assisted Living	Aged/Disabled Waiver
Per User Per Day	\$154.61	\$42.47 ¹⁰	\$15.68
Per User Per Year	\$56,433	\$15,502	\$5,722 ¹¹

Strengthening Medicaid and the Health Care System

To support the building blocks for reform, it is critical that Medicaid and the health care system provide a sound basis to sustain enhancements to support consumer choice, quality and accountability and health care cost efficiencies.

Key components of this initiative include:

- ❑ **Giving Consumers Health Care Choices Through a Health Insurance Exchange.** A central feature of the SEIU/CAPE proposal is the creation of a Health Insurance Exchange that would enable low-income uninsured and workers in uninsured small businesses to choose among a menu of commercial insurance plans with a wide range of more affordable products. The Exchange would also offer an enhanced primary care case management program in Colorado's rural areas to ensure that rural residents have access to care. For long term care consumers, the plan encourages the use of consumer directed care to give consumers a full range of health care options.
- ❑ **Ensuring Quality Care and Accountability.** While expanding coverage, this proposal also seeks to ensure quality care for all Colorado residents through significant reform of Colorado's current Medicaid program. The proposal includes the following components:
 - **Establishment of a Medical Home.** All contracts will ensure that consumers receive necessary primary care services in a timely manner.
 - **Robust reporting and transparency.** Creating effective pay for performance (P4P) programs for managed care organizations requires significant reporting systems. The managed care organizations pay for performance results and their quality reporting should be made public and readily available to consumers and providers.
 - **Hospital Pay for Performance.** Hospitals play a significant role in the health care system in general and hospital care is the single largest cost category in the Medicaid program. This proposal would tie future increases in Medicaid hospital payments to key quality performance measures, including hospital acquired infections, re-admission rates for chronic disease, initiatives

¹⁰ 05-173 Long Term Care Advisory Committee Report.

¹¹ Houser, et al, Across the States.

that address workforce issues, and pharmacy error reduction. SEIU and CAPE are also proposing the creation of a grant program to provide hospitals with incentives to make improvements that require significant up front investments, such as the adoption of electronic medical records and computerized pharmacy order.

- **Long Term Care Pay for Performance.** Pay for performance standards that seek improvements in health outcomes and consumer satisfaction should be adopted. These standards should focus on factors known to affect consumer outcomes, including staff retention/turnover, training, staffing ratios, uncovered shifts/no shows and career ladders. Additional standards should be developed in conjunction with the various long term care stakeholders, including but not limited to consumers, advocacy groups, home and community based providers and nursing home providers.

□ **Containing Health Care Costs.** To ensure the delivery of quality care into the distant future, this proposal calls for:

- Coordinating a large low-income and small business population to secure more accessible and affordable health insurance coverage.
- Cost sharing with the federal government.
- The creation of a Health Insurance Exchange to serve as a clearinghouse and a vehicle to offer high-quality basic health plans that would be uniform across the market.
- Better management of key Medicaid cost drivers like chronic disease and the introduction of effective prenatal programs.
- An emphasis on preventative care.
- The establishment of a high-quality managed care program for Colorado Medicaid.
- The creation of a Medicaid preferred drug list and the creation of a specialty pharmacy program.
- A new emphasis on home-based, long term care in anticipation of the rapid increase in the elderly population.

It is anticipated that some savings derived from effective cost containment initiatives may help support targeted, enhanced provider payments.

Colorado Health Care Reform Proposal – Required Questions

□ Comprehensiveness

What problem does this proposal address? This proposal addresses the need to create a new, sustainable platform to ensure that all Coloradans have access to necessary and appropriate health care services through a system that provides quality care in the most efficient and cost-effective manner possible. Our comprehensive reform proposal focuses on:

- ***Reducing the number of uninsured Coloradans.*** Of the 770,000 uninsured Coloradans, roughly three-quarters have income below 300% of the FPL.¹² The proposed framework for reform builds on the strengths of Colorado’s insurance industry and capitalizes on new opportunities in the Medicaid program to expand coverage to low-income uninsured and to create a platform to offer more affordable, accessible insurance to small businesses.
- ***Building a stable and sustainable platform for reform.*** A comprehensive approach to health care reform cannot succeed without a stable underlying system and network of care. Over the years, Colorado has maintained its Medicaid program, preserved individual and small group insurance markets, and built a critical network of safety net programs, including the Colorado Indigent Care Program and CoverColorado, the state’s high-risk insurance pool. This proposal outlines additional reforms to strengthen Medicaid primary, acute and long term care services to ensure a strong and sustainable base for reform. By improving quality, care management, and accountability of existing resources, the expansion builds upon a more sustainable and cost-effective delivery system for reform.

What are the objectives of your proposal?

Our goals of our health care reform proposal are to:

- Provide a path to universal health care coverage in Colorado.
- Extend health care to low-income uninsured with Medicaid-funded premium subsidies to purchase insurance to protect and improve health.
- Ensure access to quality long term care services now and in the future.
- Promote greater access, choice, personal responsibility and affordability for working families.
- Help Colorado’s small businesses purchase quality, affordable health plans for their employees.
- Ensure quality care and accountability in Colorado’s health care facilities to protect patients.

¹² U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

- Create incentives for preventive care, wellness, health education, quality outcomes and consumer empowerment.
- Adopt best practices, evidence-based medicine, and pay for performance to improve health care delivery.
- Ensure stable and sustainable funding for Medicaid, long term care services and the expansion that is fair, viable and cost-effective.

□ **General**

Please describe your proposal in detail. Charts 1, 2 and 3 summarize the specific provisions of our reform proposal, including:

- ❖ Creating a Path for Universal Health Care Coverage – Chart 1
- ❖ Improving the Long Term Care System – Chart 2
- ❖ Strengthening Medicaid and the Health Care System – Chart 3

Chart 1: Colorado – Creating a Path for Universal Health Care Coverage

Four Cornerstones for Reform	Establish Low-Income Funding Pool
<ul style="list-style-type: none"> ❖ Subsidy to purchase private insurance for low-income uninsured. ❖ Low-income pool to fund subsidies (DSH, SCHIP, other). ❖ Federal waiver to ensure funding for subsidies through the pool and flexibility to reform delivery system for uninsured. ❖ System to ensure access to affordable coverage, potentially through a Health Insurance Exchange, to facilitate the purchase of insurance for uninsured individuals and small businesses, with provisions to ensure quality and accountability. 	<p>Establish a funding pool to support subsidies for the purchase of insurance by low-income uninsured.</p> <ul style="list-style-type: none"> ❖ Dedicate funding for the pool from monies now used to cover the uninsured to : <ul style="list-style-type: none"> • Reallocate some or all of Colorado’s disproportionate share hospital (DSH) funds already spent on the uninsured. • Maximize unexpended federal SCHIP allocations. • Efficiencies in the current Medicaid program. • Leverage financing mechanisms approved in comprehensive reform waivers for unmatched state & local health care spending for the uninsured. ❖ Ensure financial support for critical safety net providers while ensuring a transition to more cost-effective care and care management.
Create System to Ensure Access to Affordable Coverage	Provide Subsidies for Low-Income Uninsured
<p>Create a system to ensure access to affordable coverage, potentially through a Health Insurance Exchange, administered by a new, quasi-public entity, to provide access to private insurance specifically tailored for the target population. The Exchange would enhance choice, coordinate health care financing from multiple sources, and engage consumers as informed and empowered purchasers. The Exchange would:</p> <ul style="list-style-type: none"> ❖ Offer products to subsidized uninsured and non-subsidized small businesses. ❖ Facilitate enrollment, certify plans, administer premium subsidies, collect premiums through payroll deductions, ensure portability, and leverage pre-tax contributions to reduce cost. ❖ Create an environment where providers would compete on price, quality, and provider networks. ❖ Provide a choice of insurance options, including: <ul style="list-style-type: none"> • Limited benefit health plan with first dollar coverage and annual benefit limit of \$25,000 to \$35,000; • A pre-paid and/or point-of-service plan; • A benchmark plan with more comprehensive coverage and higher participant cost sharing, such as the State Employee Health Insurance Plan; • State care initiatives (i.e., Colorado Indigent Care Program); and • If eligible, the Colorado high risk pool. ❖ Use the Exchange as the platform to offer more accessible, affordable products to uninsured small businesses with streamlined administration and portability for workers. 	<ul style="list-style-type: none"> ❖ Provide subsidies as part of a comprehensive framework to reform financing and delivery of health care to the uninsured. <ul style="list-style-type: none"> • Target Population. Through a voluntary program with crowd-out protections, extend access to Medicaid-funded subsidies to purchase insurance to: <ul style="list-style-type: none"> ➢ Uninsured children with income to 300% FPL. ➢ Uninsured parents with income to 250% FPL. ➢ Uninsured childless adults up to 225% FPL. • Benefits. Specify a minimum benefit tailored to the subsidized uninsured, with core benefits like ESI, including primary & preventive care, hospital, ER, prescription drug, and basic mental health services. • Delivery System. Require managed care approaches: <ul style="list-style-type: none"> ➢ Use care coordination, defined networks, higher cost sharing, wellness and healthy behavior incentives, and disease management. ➢ Ensure plans compete on price, provider networks, quality, and access. ➢ Provide Medicare or reasonable market rates. • Personal Responsibility. Create a “culture of insurance” with a “medical home,” incentives for consumers and providers, and market competition. • Employer-Sponsored Insurance. Allow ESI opt-out. • Cost Sharing. Provide subsidies on a sliding scale based on income with enforceable cost sharing. <ul style="list-style-type: none"> ➢ Only point-of-service co-pays under 100% FPL. ➢ Under 5% of income, between 100-200% FPL. ➢ Over 200% FPL, could exceed 5% of income. ➢ No deductibles; ensure primary/preventive care.
Ensure Quality & Accountability	Obtain Federal Medicaid Agreement
<p>Pursue strategies to promote quality, safety and best practices:</p> <ul style="list-style-type: none"> ❖ Utilize managed care approaches with a “medical home,” and care coordination with standards to support quality, consumer direction, disease management, efficiency, and access to primary and preventive care in a timely manner. ❖ Leverage evidence-based care, quality measures & pay for performance to improve health and health care outcomes. ❖ Utilize health information technology to reduce errors and improve efficiency and transparency. 	<p>Obtain a Medicaid section 1115 waiver to reform financing and delivery of health care for the uninsured.</p>

Chart 2: Colorado – Improving the Long Term Care System

Cornerstones for Improving the System	Promote Least Restrictive Care Settings
<ul style="list-style-type: none"> ❖ Serve as many persons needing services as possible. ❖ Ensure that care is available in least restrictive setting and of the highest possible quality. ❖ Preserve consumer choice in care plan and service delivery. ❖ Protect the fiscal integrity of the long term care system. 	<ul style="list-style-type: none"> ❖ Develop nursing facility right-sizing strategy. <ul style="list-style-type: none"> • Establish right-size reimbursement incentives, such as occupancy standards, and more targeted reimbursement for non-care cost centers. • Assist workforce training and transitioning to provide community based care. • Provide technical assistance to nursing homes to help expand their continuum of care. ❖ Provide adequate reimbursement in all settings. <ul style="list-style-type: none"> • Modify rate setting to minimize unreasonable disparities between institutional care and home and community-based care. • Develop acuity-adjusted rates for non-institutional providers to encourage these providers to treat higher acuity individuals. • Consider a cost-based reimbursement system for all home and community-based services, including assisted living and adult day care centers. ❖ Expand all home and community-based services. <ul style="list-style-type: none"> • Promote PACE, SNP and home and community based care across the state. ❖ Reserve nursing facility utilization for highest acuity levels. ❖ Streamline eligibility to avoid unnecessary institutionalization by allowing services for those reporting few assets, subject to final eligibility determination. ❖ Implement spend down for home and community based services, so individuals may receive coordinated care prior to Medicaid eligibility.
Enhance Care Delivery Options	
<ul style="list-style-type: none"> ❖ Develop and implement models of care that integrate services and care coordination for Medicaid and Medicare: <ul style="list-style-type: none"> • Medicare Special Needs Plans (SNPs) • Coordinated Care Programs • PACE and similar programs ❖ Promote consumer directed care in all integrated models. ❖ Develop more integrated State-funded Program options. ❖ Develop Veterans’ options for home and community-based care. 	
Manage for Quality	Improve Housing Options
<ul style="list-style-type: none"> ❖ Link payment to performance for all long term care providers. <ul style="list-style-type: none"> • Establish a long term care quality management committee. • Develop measurable benchmarks and performance standards that include workforce measures. • Ensure accountability through accurate and timely reporting and administrative oversight. ❖ Establish a public authority to support high quality home and community-based services. ❖ Establish cabinet level intra-department oversight. ❖ Develop a training program for care providers including: <ul style="list-style-type: none"> • The patient’s right to direct his/her care, patient safety and privacy. • Career progression coaching. • Training that addresses job displacement due to changes in technology, organizational structure, etc. • Develop a dedicated fund to support these training and upgrading efforts. • As a priority, focus on specialized units and specialized care, and consistency in staffing. ❖ Establish protocols and procedures to address situations in which a service provider does not arrive on time. ❖ Promote retention of high quality long term care workforce. <ul style="list-style-type: none"> • Consider a tiered reimbursement system to provide higher reimbursement for facilities and providers who offer comprehensive health benefits to their employees, and those that contribute beyond an established threshold toward the cost of employee health care. 	
Ensure Fiscal Sustainability	<ul style="list-style-type: none"> ❖ Increase access to affordable housing for long-term care consumers. <ul style="list-style-type: none"> • Establish housing set-asides and a process to give priority placements to long-term care consumers. • Develop models to integrate housing and support services. ❖ Increase availability of affordable and accessible housing. <ul style="list-style-type: none"> • Establish a housing fund for non-profit developers to create accessible, affordable housing. ❖ Increase technical assistance with housing. <ul style="list-style-type: none"> • Dedicate local housing experts to assist consumers and care managers to obtain affordable and accessible housing. • Assist nursing homes, developers and others in accessing programs to help finance affordable and accessible housing.
<ul style="list-style-type: none"> ❖ Secure all available federal funds for current long term care programs. ❖ Facilitate coordination between programs funded by Medicaid and those funded by other funding sources. ❖ Reinvest right sizing savings in enhanced home and community based services. ❖ Claim federal Medicaid matching funds for care provided to Veterans. ❖ Reconsider nursing home tax to support quality care for those of highest acuity. 	

Chart 3: Colorado – Strengthening Medicaid and the Health Care System

Cornerstones for Strengthening the System	Expand Managed Care Options & Strategies
<ul style="list-style-type: none"> ❖ Ensure a sound “base” Medicaid program. Even as Colorado considers expanding coverage to the uninsured, the basic Medicaid program should be strengthened and enhanced. ❖ Ensure Quality Care and Accountability. Implementing targeted reforms in Colorado’s existing Medicaid and SCHIP programs will improve the quality of and increase the accountability for the care delivered, strengthening the foundation for care delivery within Medicaid. ❖ Contain Health Care Costs. Colorado Medicaid can take advantage of strategies that will contain costs while not jeopardizing the quality of or access to health care. Improved efficiencies will help the State maintain a viable Medicaid program for its residents. ❖ Ensure Adequate Access. Coverage expansions can create opportunities to enhance provider rates in targeted ways to achieve reform objectives. 	<p>Experience in other states strongly suggests that managed care increases access, improves quality and care coordination, and is more cost-effective than unmanaged fee for service programs. To create an efficient and more cost-effective delivery system:</p> <ul style="list-style-type: none"> ❖ Strengthen managed care in the Colorado Medicaid program. Leverage the savings and efficiencies in the delivery system to extend health care to more uninsured. ❖ Provide both a capitated model and a managed fee-for-service model to extend care management to urban and rural areas. ❖ Create a pay for performance system to align payment incentives with performance-driven goals for expected outcomes of the managed care organizations (MCOs) for ensuring access, high quality and cost-effective care.
	Establish Capitated Managed Care
	<p>Establish statewide, full-risk capitation managed care.</p> <ul style="list-style-type: none"> ❖ Incorporate pay-for-performance principles within managed care contracts to provide incentives for high quality and cost effective care. ❖ Focus on care management instead of cost management. ❖ Require robust disease management programs for chronic conditions that include management of consumers with chronic disease co-morbidities. ❖ Incorporate case management for complex medical conditions and high-cost cases. ❖ Emphasize comprehensive prenatal care case management, including smoking cessation, and other wellness strategies and oral health. ❖ Promote the concept of a medical home along with a focus on ready access to primary health care to help ensure cost-effective, quality health care. ❖ Incorporate incentives to promote health and wellness to achieve long-term savings and improve the health status of Medicaid recipients. ❖ Allow recipients a choice of managed care plans based on price, benefits, and provider networks. ❖ Require robust reporting and transparency to improve health outcomes and allow consumers to make more informed choices about the plans and providers they select.
Link Hospital Pay to Performance	Offer Alternative Primary Care Case Management (PCCM)
<p>Develop a performance-based hospital reimbursement system to:</p> <ul style="list-style-type: none"> ❖ Provide incentives for hospitals to actively engage in quality improvement strategies. ❖ Establish payment rates based on key quality of care performance benchmarks in areas such as: <ul style="list-style-type: none"> • Hospital-acquired infection rates. • Readmission rates for chronic diseases. • Pharmacy order error reduction. • Implementing and maintaining an Electronic Medical Record system. • Hospital investments in quality-related improvements, including measures to address the workforce shortage. 	<p>Provide flexibility for an alternate delivery system of enhanced PCCM for rural areas where the full-risk capitation model is not available.</p> <ul style="list-style-type: none"> ❖ Engage a vendor to manage the primary care delivery network. ❖ Incorporate pay-for performance targets to align incentives to promote high quality, cost effective care. ❖ Utilize the Medicaid program’s capacity for functions such as enrollment and eligibility, pharmacy benefits management, prior authorization and other utilization review mechanisms.
Improve Pharmacy Benefits Management	
<ul style="list-style-type: none"> ❖ Implement a Preferred Drug List (PDL) to: <ul style="list-style-type: none"> • Increase utilization of more cost-effective generic drugs. • Negotiate better rebate agreements with manufacturers for preferred drugs and devices on the PDL. ❖ Participate in a multi-state purchasing pool to leverage the negotiating power of a larger pool for both the ingredient costs of drugs and rebates. ❖ Implement a specialty pharmacy program for high cost products such as biologic agents, oncology drugs, blood factor products and other injectibles. This provides potential to: <ul style="list-style-type: none"> • Negotiate lower ingredient prices for products included in the specialty pharmacy program. • Secure supplemental rebates for the items covered through the specialty pharmacy program. • Improve care coordination for individuals who need specialty products. ❖ Have appropriate safeguards in place, including a Pharmacy and Therapeutics Committee that will report to the Medicaid Agency and advise the State on issues pertaining to the PDL and specialty pharmacy program. 	

Who will benefit from the proposal? Many groups in Colorado will benefit from the proposal.

- Low-income children, parents and childless adults will benefit from Medicaid-funded subsidies to access health care, and small business will have greater access to a choice of affordable health insurance products. Small business owners who cannot now afford to offer health insurance and their employees will benefit because they will be able to access affordable coverage, improving business competitiveness and the ability to attract and retain qualified employees. Coloradans will benefit from a healthier population as a result of increasing the number of people with stable and affordable health insurance, a more viable safety net system, and reduced premium for all other private payers.
- Health care providers will benefit from the increased number of individuals with health insurance and the anticipated reduction in uncompensated care.
- Insurers and agents will benefit because the foundation for expanding coverage is through the commercial insurance market.
- Safety net providers will benefit from a more cost-effective delivery system that provides coverage-based payments for care provided to low-income uninsured. By providing a subsidy to make coverage more affordable and choice to make coverage more attractive and accessible, the goal is to create a culture of insurance that spreads risk more fairly and that pays providers adequately for services delivered.
- Medicaid recipients and Colorado taxpayers will benefit from strategies that will reduce costs and improve the coordination and quality of acute and long-term care services. The elderly and persons with disabilities will benefit from high quality, consumer-directed care delivered in a cost-effective manner in the least restrictive and clinically appropriate setting. Nursing facilities will benefit from a higher acuity caseload and long term care workers will benefit from tiered reimbursement that is designed to encourage health insurance coverage.
- The state and federal Medicaid program will benefit from more appropriate use of public funds and the increased numbers of individuals with health coverage. Avoiding or reducing more costly acute or long term care through access to primary and preventive care should yield significant savings. The public sector will also benefit from more integrated and coordinated long term care and home and community based options.

- SEIU and its members in Colorado benefit by preserving a viable health care system that provides employment and by increased access to health care coverage for its members.
- All Coloradans will benefit by having access to health insurance and the benefits of a more efficient, effective and coordinated health care delivery system.

Who will be negatively affected by the proposal? Our reform is crafted carefully to minimize the extent to which Coloradans and key stakeholders are negatively impacted. By creating a platform to improve access to coverage and strengthen existing safety net providers and commercial insurance, the proposal is designed to complement and build upon Colorado's existing health care system. Some changes, however, may be met with resistance.

- Because this proposal would integrate some Medicaid Disproportionate Share Hospital (DSH) funds into the reform, safety net providers may be concerned. We believe greater integration of DSH into the reform will be a critical factor in securing federal approval for additional federal funding and will ultimately advantage the safety net care system overall through less uncompensated care.
- Insurers may be concerned that a reform effort will weaken their client base. However, our proposal relies on a new model to move more people into commercial insurance, using Medicaid funds to defray the costs of premiums.
- For long term care, some nursing facilities may be impacted by rate setting changes that focus on post-acute rehabilitation care and higher acuity caseloads.
- Though we have structured our proposal to take maximum advantage of additional federal funding, and reallocate existing Medicaid funds (such savings from efficiencies and a portion of DSH), additional state funds may be needed to achieve the goals of the Blue Ribbon Commission for Health Care Reform.

Finally, there is considerable flexibility built into the reform platform we propose. We believe this will allow the state to navigate stakeholder concerns, and determine the appropriate implementation and administration strategy while still moving ahead to expand coverage, improve health and reduce costs.

How will your proposal impact distinct populations (e.g., low-income, rural, immigrant, ethnic minority, disabled)? Distinct populations would benefit from the reform, including:

- Low-income Coloradans will have access to affordable health coverage, and will be able to choose the products that best meet their needs. Because they will own their policy, coverage will be portable and move with them as life situations, such as jobs or marital status, change.
- Our reform plan is statewide. Coloradans who reside in rural areas of the state may experience greater access to coverage as insurers expand their coverage areas to respond to the new insurance markets created by this reform.
- Since the foundation for this reform platform will be built upon commercial insurance products, we anticipate that, in order to compete for market share, insurers will develop products that will be responsive to rural citizens, as well as to ethnic minority and disabled populations.
- Our proposal incorporates strategies to improve long-term care. This would result in higher quality, more coordinated care for the elderly and persons with disabilities, including those in rural areas.
- Though immigrants would not be eligible for Medicaid-funded premium subsidies due to federal regulations, their care will continue to be funded with allowable state and federal funds. However, we anticipate that there may be greater capacity in the state's safety net system to provide needed care for immigrants as the state reduces significantly its number of uninsured individuals.

Please provide any evidence regarding the success or failure of your approach. Please attach. Recent changes in federal law and policy and innovative Medicaid-funded state health care reform initiatives across the country offer new strategies to create a platform for broad-based, comprehensive reform leveraging a Medicaid waiver and new authority under the federal Deficit Reduction Act to expand coverage to uninsured populations. Two articles which describe key features of other state-based reform initiatives, components of which are incorporated in our proposal, are attached as Appendices A and B.

How will the program(s) included in the proposal be governed and administered? In other states that have implemented or proposed a market-based approach to reform, a Health Insurance Exchange has been incorporated as an independent, quasi-governmental entity. Colorado could establish an Exchange to facilitate the purchase of private sector health insurance products for

uninsured individuals and small businesses. The Exchange, in consultation with the State Medicaid Agency and the State Department of Insurance, could administer the program.

The Exchange would have a Board, an Executive Director, and limited full-time staff. A third-party contractor could provide all administrative support for the Exchange. Funding for administrative costs would be included in plan premiums. The State Medicaid agency would oversee the determination of eligibility for the expansion population and would administer all Medicaid waiver requirements. The Exchange would certify and offer a choice of affordable products, providing options for individuals, families, and for small businesses, facilitate enrollment, administer premium subsidies, coordinate with employers on work site enrollment, payroll withholding, and any voluntary employer contributions, ensure portability and leverage pre-tax contributions to reduce cost, and collect and maintain data on health care outcomes.

Using these design principles, the Exchange will create a platform to establish the transparent purchase of health care for the low-income uninsured and small businesses. In particular, the Exchange will:

- Leverage market-based competition to offer high value health insurance.
- Compete on price, quality, and provider networks, as in the commercial marketplace.
- Leverage Medicaid-funded subsidies to help uninsured children, low-income parents and childless adults purchase private health insurance products, with coverage that meets State guidelines and that is portable, cost-effective and seamless, providing individuals a new incentive to increase family income without the loss of health care.

While the functions of the Exchange are critical to the success of reform and expansion, the creation of an Exchange could be accommodated through the existing administrative infrastructure. Alternatively, the State could perform the functions outlined above, or could choose to do so initially with a phase-in to the Exchange at a later date.

To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g., federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary? This proposal will require approval of a federal Medicaid s. 1115 waiver to cover childless adults, and related Medicaid state plan amendments (SPAs) to establish eligibility for children and low-income parents. Flexibility to modify the delivery system, to design benefits tailored to the uninsured

populations and to leverage and maximize federal financing would also require approval through a Medicaid section 1115 waiver. State enabling legislation and state budget authority will also need to be addressed prior to implementing the reform proposal. Medicaid SPAs and home and community based waivers would need modifications to incorporate the proposed reforms.

How will your program be implemented? How will your proposal transition from the current system to the proposal system? Over what time period? Our proposal is structured to extend coverage initially to: (1) children up to 300% FPL; (2) parents up to 250% FPL; and (3) childless adults up to 225% FPL. The State has significant flexibility, however, in how to implement the plan. Depending upon available resources, the State could implement the Exchange and full coverage expansion for low-income children, parents and childless adults at the same time, or could opt to phase in the expansion, beginning with children, then parents, and finally childless adults. Alternatively, the state could expand access first to children, parents and childless adults under 100% FPL, then add groups incrementally at higher income levels.

Another approach could be to begin implementation with the State performing some of the functions that would be performed by the Exchange until enrollment reaches a certain level and then proceed with implementing the Exchange.

Transitioning from the current system to the reform will require federal approval of the waiver and related state plan amendments for Medicaid-funded subsidies. Depending on whether the state initially implements an Exchange and whether a phased-in is used, a minimum of six months will likely be required to implement the reform once federal approval is received.

□ Access

Does this proposal expand access? If so, please explain. Yes, this proposal significantly expands access. Under our proposal, which extends coverage to low-income uninsured, including children up to 300% FPL, parents up to 250% FPL and childless adults up to 225% FPL, more than 490,000 of the state's 770,000 uninsured, or 64%, would have access to health insurance. The State could choose, at any time, to pursue federal approval to extend coverage up to the maximum allowed under Medicaid of 300% FPL, expanding coverage up to 73% (561,000) of the uninsured.¹³

¹³ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

Additionally, the proposal provides a platform to extend more accessible and affordable coverage without subsidies to small businesses and, as the state moves forward to ensure universal coverage for all uninsured in Colorado, to any remaining uninsured.

Finally, the proposal is designed to increase access for rural long term care consumers, and to provide greater access to non-institutional, integrated care for all Coloradans.

How will the program affect safety net providers? This proposal is designed to strengthen Colorado's safety net system. As more Coloradans are able to obtain health care services covered by insurance, safety net providers would be an integral part of the system to provide the capacity and services needed by the expansion population, and would submit claims and be reimbursed by the insurer(s). Safety net providers will benefit from a more comprehensive delivery system that provides coverage-based payments for care provided to low-income persons who are currently uninsured. By providing a subsidy to make coverage more affordable and choice to make coverage more attractive and accessible, the goal is to create a culture of insurance that pays providers adequately for services delivered.

In addition, safety net providers would continue to fulfill their critical role for populations not eligible for Medicaid-funded subsidies, including immigrants.

□ **Coverage**

Does your proposal “expand health care coverage”? (Senate bill 06-208) How? Yes, this proposal significantly expands access to health care coverage. Under our proposal, more than 490,000, or 64% of currently uninsured Coloradans would have access to health coverage, making it easier for them to purchase health care services. The State could choose, at any time, to pursue federal approval to extend subsidies up to the maximum allowed under Medicaid of 300% FPL, which would expand coverage up to 73% (561,000) of the uninsured. The proposal would also extend long term care services to higher-income individuals and Veterans.

How will outreach and enrollment be conducted? We anticipate that outreach and enrollment will be most effectively accomplished by building off systems currently used to make residents aware of Medicaid and safety net programs and services. In addition, we anticipate that insurers that offer products on the Exchange will advertise and raise awareness of not only their products, but of the new coverage opportunities as well.

By coordinating with the Exchange on workplace enrollment, payroll withholding and tax sheltering of worker contributions, a significant number of low-wage, uninsured workers will be enrolled into mainstream health plans with affordable premiums, consumer choice, and stable coverage.

Participation rates are substantially higher where workers enroll at their workplace and make their contributions through payroll deduction than through separate, stand-alone enrollment and billing processes. Current data show that many low-income workers and parents offered employer coverage do participate, and they often contribute substantially more for employment-based coverage than research indicates they would pay to enroll in a public program.¹⁴

Additionally, experience in other states has shown that effective outreach to parents when “family-based coverage” becomes available is the most effective strategy to increase enrollment among low-income children who are eligible for Medicaid and SCHIP, but who are not yet enrolled.¹⁵ Of the state’s uninsured, approximately 110,000, or 14%, are low-income children with income below 200% of the FPL who may be eligible currently for Medicaid or SCHIP.¹⁶

For long term care, outreach would be conducted through existing single entry points.

If applicable, how does your proposal define “resident”? Our proposal would use the definition of “resident” used by Colorado for its Medicaid program.

□ **Affordability**

If applicable, what will enrollee and/or employer premiums-sharing requirements be?

This plan would provide premium assistance for the purchase of health insurance products to uninsured not eligible for government programs and unable to access private insurance. Health care premiums will be subsidized, on a sliding fee scale, for those in the expansion population.

- For persons in the expansion population with income under 100% of the FPL, cost sharing will be limited to co-payments at the point of service. Unlike Medicaid, co-payments would be enforceable. Health plan premiums for this very low-income expansion group will be fully subsidized.

¹⁴ Ed Neuschler and Rick Curtis. “Use Of Subsidies To Low-Income People For Coverage Through Small Employers.” Health Affairs. Health Tracking: Market Watch Web Exclusive. 21 May 2003. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.227v1/DC1>

¹⁵ “Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy.” The Kaiser Commission on Medicaid and the Uninsured. Jan. 2007. Pp. 40. <http://www.kff.org/uninsured/upload/7476.pdf>

¹⁶ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

- For persons with income between 100% and 200% of the FPL, cost sharing would be comprised of enforceable co-payments and premium payments, on a sliding scale based on income, up to a maximum of 5% of income.
- For persons with income above 200% of the FPL, cost sharing would be composed of enforceable co-payments and premium payments, and could exceed 5% of income.

In addition to enforceable co-payments and sliding scale premium payments, plan costs would be offset by utilizing voluntary employer contributions and pre-tax contributions from employers and employees to support plan costs. By taking advantage of existing federal and state tax subsidies available for employer contributions and for workers' contributions through their employers, the amount of state and federal subsidies required for the expansion population will be reduced.

The new insurance products for non-subsidized small business workers are designed to complement, not supplant, ESI and existing individual and small group health insurance coverage. It is expected that plans will be designed to be relatively consistent with those for the subsidized expansion population. Accordingly, plans will be required to utilize managed care approaches and benefits that are comparable to ESI and small group market plans.

How will co-payments and other cost-sharing be structured? Benefit coverage, premium subsidies, copayments, and annual limits will be designed to ensure coverage for the maximum number of Colorado's uninsured citizens within available funding by crafting a reform plan to:

- Focus on primary, acute and preventive care most needed by the target populations.
- Encourage enrollment with significant subsidies for premiums, particularly for low-income uninsured.
- Utilize co-payments to control inappropriate use and to promote access to services in the most appropriate setting. Copayments would range from \$10 for primary care office visits to \$100 for an inpatient hospital admission.
- Waive copayments and required cost sharing through a wellness/healthy behavior incentive to encourage primary and preventive care, including an annual physical, a health risk assessment and follow-up, and evidence-based care for prevention, high-risk individuals and chronic diseases.

- Leverage cost-effective plan rates for market products (potentially through the use of an annual benefit limit of \$35,000 to \$50,000 to limit exposure for catastrophic care costs, to minimize risk, and to foster participation of competing plans), with additional plan options to provide a choice of coverage and cost sharing.
- Continue to support DSH payments to fund catastrophic or uncompensated care costs not covered under the reform program.

For long term care, copayments would only be applicable to the Medicare component and the home and community based spend down.

□ **Portability**

Please describe any provisions for ensuring that individuals maintain access to coverage even as life circumstances (e.g., employment, public program eligibility) and health status change. The Exchange would provide coverage to low-income uninsured eligible for a subsidy and non-subsidized small businesses. Insurance coverage through the Exchange would be owned and controlled by the individual. As such, coverage would be portable, and workers, if they continue to meet income guidelines, could retain their health care coverage as they move to other jobs, work part-time or multiple jobs, or remain employed by small businesses eligible to participate in the Exchange. Having a seamless program that coordinates coverage under the expansion with employers and employer-sponsored insurance and that interfaces with Medicaid and SCHIP (some family members may be eligible for and covered under these programs) will be instrumental in ensuring continuity and access to coverage as circumstances change. All low-income uninsured individuals who qualify for a subsidy and uninsured small business without a subsidy would be eligible to participate in the Exchange regardless of health status. An option on the Exchange would be to allow participation in the state's high risk pool for individuals who would be eligible as high-risk; in this case the State could explore opportunities to provide a higher subsidy to ensure enrollment and access to benefits for higher-cost individuals in the high risk pool instead of commercial products offered through the Exchange.

For long term care, the proposal recommends options for state only or Medicare only programs that help individuals maintain integrated and coordinated care in the community.

□ **Benefits**

Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations. The reform platform leverages the commercial insurance market with coverage and benefits tailored to the expansion population, with a choice of affordable products, with linkages to employer sponsored insurance (ESI), and the individual and small group markets, and with underlying principles that provide options for distinct populations (urban-rural, different ethnic minorities).

All plans will be required to manage care to enhance services, including medical homes with defined networks, basic health benefits, tiered cost sharing, healthy behavior incentives, disease management, and drug formularies. Benefit packages will be comparable to ESI and small group market plans.

In extending health insurance coverage to the uninsured, our reform proposal assumes:

- A minimum, basic benefit package with coverage for primary and preventive care, hospital and emergency room services, prescription drugs, and mental health services that cover basic health services and that are the core of most health insurance plans.
- First dollar coverage with no deductibles to ensure that consumers make a connection with the health care system, especially primary care.
- Streamlined administration to simplify enrollment, to reduce administrative burdens and cost for insurers, employers and plan participants, and to create efficiencies through lower administrative costs.
- Care management and managed care delivery systems with risk-based capitation payments and enhanced primary care case management to:
 - Ensure access to care and adequate provider networks;
 - Focus on prevention and quality in the delivery of care, including disease management, patient safety and improved outcomes for health and performance;
 - Prevent fraud, waste and abuse in the provisions of health care services;
 - Utilize a “medical home” to promote coordinated care that leverages best practices and evidence-based medicine, and that reduces duplication of services;

- Build on initiatives in the private insurance market to provide financial incentives, education and support for healthy living and improved health outcomes;
- Provide the platform and infrastructure to extend cost-effective, quality care to all Coloradans.
- Market competition to reduce costs, with insurers competing on the basis of value. The Exchange will certify products for uninsured individuals eligible for low-income subsidies and for uninsured small businesses based on affordability, quality, provider networks and use of approved benefit plans.
- Clear communications for consumers to easily understand their options and choices and information to assist enrollees with an informed, cost-conscious choice.

For long term care, the individual consumer's clinical and social needs will determine the scope and duration of services needed.

Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g., Small Group Standard Plan, Medicaid, etc) and describe any difference between the existing benefit package and your benefit package.

The proposal would offer a range of products through the Exchange and consumers would be able to choose the product that best meets their needs. Products would include a “core benefit” plan for relatively healthy individuals seeking access to basic, affordable health coverage and a more catastrophic coverage type of plan for individuals with chronic or other health conditions who may be seeking coverage for potentially higher cost care related to their health status.

Based on available information, we believe that the premium, cost sharing and benefit structure for the “basic benefit” plan we propose for the expansion population could be considered comparable to Colorado's Small Group Standard HMO plan.¹⁷

Similarities include:

- Premiums for our proposal would be established based on age, gender and residence of the enrollee. Medical underwriting would not be used as a basis for determining premium levels.

¹⁷ “2000 Small Group Health Insurance Premiums For Colorado.”
<http://www.dora.state.co.us/INSURANCE/pb/sg2000.pdf>

- Enrollees would be responsible for cost-sharing obligations for most services; however there would be no deductibles.
- Covered services would include primary and preventive care, prescription drugs, hospital care (inpatient, outpatient and emergency room), mental health services, physical therapy, speech therapy and occupational therapy, laboratory and radiology services.
- Enrollees would receive their care through a network provider.

Differences include:

- Individuals who select the basic benefit plan would be subject to an annual benefit maximum to be determined by the State. Typically, these annual benefit maximums would be between \$25,000 and \$50,000. (Choosing a lower annual benefit limit would allow the State to keep premiums at the lowest possible levels for a generally young and healthy uninsured population).
- The proposal does not assume a waiting period for coverage of pre-existing conditions.
- Premium subsidies would be available for low-income enrollees.
- Total out-of-pocket costs (including premium and cost sharing obligations) would not exceed 5% of the family's income for persons with income under 200% of the FPL, and potentially less than 5% for the very low income (those with income under 100% of the FPL).
- The individual owns the insurance policy and, therefore, has the right to retain coverage regardless of job or other life changes as long as the individual remains eligible for the program.
- The proposal would incorporate a requirement for a healthy behaviors/wellness incentive.

In addition to a core benefit plan, alternative plans could be offered, including a pre-paid and/or point-of-service health plan, a benchmark plan with more comprehensive coverage (like the State Employee Health Insurance Plan), a state care program (like the Colorado Indigent Care Program), or, if eligible, the State's high risk pool, CoverColorado. For those who qualify for the State's high risk pool, a higher premium subsidy could potentially be provided.

Quality

How will quality be defined, measured, and improved? Quality will be improved through a number of initiatives that underlie the foundation for reform in the current Medicaid program (for both primary and acute care and long term care services) and by the extension of these initiatives to the expansion population covered under the reform.

Quality would be defined through measures that establish benchmarks for health and health care outcomes, performance standards and use of best practices for:

- Appropriate, evidence-based care;
- Use of comprehensive, shared patient records;
- Effective care coordination;
- Efficiency on a large scale.

To the extent possible, quality objectives would be supported in the Medicaid program by focusing on purchasing strategies that pay for cost-effective services, that utilize plans that control costs by managing care, and that involves providers and consumers as partners in defining quality measures for care. By monitoring care, setting benchmarks, ensuring standardized training, paying for performance, publishing outcomes, and improving coordination between Medicaid, SCHIP, and other payers, individuals would be able to seek quality care that meets their needs, regardless of whether that is primary, preventive, acute or long term care services and whether that care is provided through the existing Medicaid program or the Exchange.

How, if at all, will quality of care be improved (e.g., using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?) The proposal would improve quality of care through a series of initiatives to:

- Utilize managed care models that promote and ensure quality.
- Incorporate Pay-for-Performance (P4P) by:

- Establishing contractually-based and measurable performance standards in all contracts, with incentive-based payment provisions.
 - Linking hospital payments to performance against established benchmarks in areas such as hospital-acquired infections, pharmacy order error rates, readmission rates for chronic diseases as well as providing incentive-based payments for implementing and maintaining electronic medical records and other quality-related improvements.
 - Structuring all contracts to align payment incentives with performance-driven goals, emphasizing care management instead of cost management.
 - Building P4P benchmarks in long-term-care program design and evaluation in areas such as health outcomes, satisfaction, staffing ratios, staff retention/turnover, training, and uncovered shift/no shows.
- Leverage evidence-based care, quality measures and performance standards.
 - Utilize health information technology to reduce errors and improve efficiency.
 - Ensure accountability through robust reporting and transparency.
 - Promote the concept of a medical home along with ready access to primary care services in a timely manner.
 - Promote consumer-directed care in all models of managed care.
 - Require disease management programs for chronic conditions as well as case management for high-cost and complex cases.
 - Emphasize comprehensive prenatal care case management.
 - Develop and implement models of long term care that integrate services and care coordination for Medicaid and Medicare in person-centered care plans:
 - Medicare Special Needs Plans
 - Coordinated Care Programs

➤ PACE and similar programs.

- Establish new oversight structures dedicated to quality care improvements, including a long-term care Quality Management Committee and a Public Authority to support home and community-based services.
- Develop a training program for care providers that addresses patient safety and privacy, the patient's right to direct his/her care, career progression, and skills retooling to respond to the shift to more home and community based care and to job displacement.
- Implement a specialty pharmacy program to include care coordination for individuals who require specialty pharmacy drugs, biologics and other injectibles.
- Ensure availability of affordable products to encourage participation in a health plan.
- Provide premium subsidies and limits on cost sharing for low income Coloradans to increase the likelihood that they will enroll in a health plan and access primary and preventive care.
- Reduce uncompensated care costs by allowing scarce resources to be more effectively targeted to uninsured persons.
- Ensure care coordination in all delivery models.
- Promote wellness and healthy behavior incentives.

❑ **Efficiency**

Does your proposal decrease or contain health care costs? How? The proposal would reduce health care costs through a number of initiatives to:

- Develop a more efficient and cost-effective system to provide care to the uninsured with a focus on care management, primary care and prevention, and benefits tailored to the target population.
- Leverage market competition and choice to reduce costs.
- Reduce uncompensated care costs and cost shifting to employer plans and other payers.

- Creative incentives for quality, cost-effective care in the most appropriate and least restrictive settings.
- Implement targeted reforms in Colorado's Medicaid and SCHIP programs to incorporate strategies that contain costs, such as:
 - Greater use of capitated managed care and primary care case management to ensure access, quality and more cost-effective care through initiatives to manage care, implement pay for performance, incorporate evidence-based care, promote health and wellness and improve health and health care outcomes through performance benchmarks.
 - More robust disease management for chronic conditions to incorporate best practices and evidence-based medicine in the delivery of care.
 - Reporting, monitoring and transparency to improve health and health care outcomes and to allow consumers to make cost-effective choices for plans and providers.
 - Hospital payments linked to quality of care performance benchmarks to contain hospital costs for hospital-acquired infections, readmissions for chronic diseases and pharmacy errors.
 - Improved pharmacy purchasing strategies to garner savings through a preferred drug list (PDL), a multi-state purchasing pool, and a specialty pharmacy program.
- Implement long term care reforms that contain health care costs, such as:
 - Revising long term care eligibility to ensure that the most restrictive setting (institutional care) is limited to those with the highest acuity levels.
 - Revising long term care offerings to provide more integrated and coordinated services for not only Medicaid funded services, but also programs funded solely by state funds.
 - Creating additional infrastructure, such as increased consumer directed care, to help make community-based care a more viable option for more Coloradans to ensure cost-effective care in the least restrictive setting.

To what extent does your proposal use incentives for providers, consumer, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain. The proposal creates incentives for providers, consumers,

health plans/insurers to minimize costs and to maximize access and quality in the delivery of health care services both within Medicaid for primary, acute and long term care services and within the expansion program for health care through commercial insurance products. The key incentives that would be incorporated for each of the groups cited above include:

- **Providers** – Use of appropriate care management, with effective care coordination and a focus on quality and prevention in the delivery of care, with incentives for disease management, pay for performance, evidence-based care and benchmarks for health and health care outcomes.
- **Consumers** – Access to affordable insurance with an emphasis on primary care and prevention and choices of insurance to best meet consumers’ needs, with incentives for wellness and healthy behaviors.
- **Plans/Insurers** – Opportunities to leverage choice, market competition and portability to increase access to more affordable insurance with Medicaid-funded subsidies for a large segment of the uninsured population.

Does this proposal address transparency of costs and quality? If so please explain. Yes, this proposal would utilize reporting and transparency for costs and quality to improve health and health care outcomes and to help consumers make more informed choices about the plans and providers they select for Medicaid primary, acute and long term care services, and state-only funded long term care services.

How would your proposal impact administrative costs? The proposal could build off current initiatives in Colorado for health care reporting and monitoring, including encounter data and HEDIS reporting. The proposal could utilize funding currently appropriated for Medicaid and SCHIP, and additional funding that could be available for health care reform through the low-income pool.

❑ **Consumer Choice and Empowerment**

Does your proposal address consumer choice? If so, how? Consumer choice, consumer empowerment and consumer-directed care underlie the proposed reforms for Medicaid’s primary and acute care services, long term care services and the proposed expansion of health care to uninsured populations. The proposal addresses more consumer choice by: (1) providing a range of health insurance plans offered by a newly-created Health Insurance Exchange; (2) enhancing

consumer-centered initiatives for primary, acute and long term care services; and (3) requiring best practices that effectively assist consumers to make informed decisions about their health plans and health care.

How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions? The proposal would utilize the Exchange to inform consumers of plans, providers and health care options available, and would support consumers, providers, plans and providers in making informed choices with appropriate information on quality, access, cost and provider networks.

New and enhanced systems of more managed care would include information and processes to assist consumers in care plan development and personal responsibility for health. The proposal would promote wellness and healthy behaviors to assist consumers in making good health care decisions.

For long term care, the proposal would utilize the existing single entry points but with greater access to information about long term care options, as well as information about the quality of services.

□ **Wellness and Prevention**

How does your proposal address wellness and prevention?

All plans offering products through the Exchange for the subsidized population would be required to incorporate a healthy behaviors or wellness initiative to provide financial incentives, education, and support to achieve improved health and health care outcomes.

Healthy behaviors/wellness programs will be required to identify at least four lifestyle behaviors for which members, in conjunction with their primary care provider, would be responsible to actively follow a treatment plan and guidelines to reach a health goal. Intervention for lifestyle behaviors should have measurable benchmarks and a treatment plan, education and support to assist members in meeting their goals. Potential lifestyle behaviors/interventions could include a range of preventive behaviors.

Through the Exchange, managed care plans would be required to offer enrollees an opportunity to complete a health risk appraisal. For employed enrollees, employers will be given the option to be a part of the health partnership.

Components of a healthy behaviors/wellness program could specify:

- An assessment of health status based on a health risk appraisal.
- Follow-up with a primary care physician within 90 days of plan enrollment, with no co-pay for this physician follow-up.
- Based on the results of the appraisal, compliance with a treatment plan developed with the physician for healthy behavior interventions as part of the enrollee's plan of care.
- Financial incentives to encourage and reward healthy behaviors.
- Education, including classes, information on a website, or direct mailings. The plan should also offer enrollee-specific educational plans, tailored to the health status and needs of individual enrollees.
- Support for enrollees should include ongoing access to health professionals who can counsel and provide coaching and support.
- Employers would also be required to support healthy behaviors by having smoke-free work environments, encouraging employees to take the health assessment and participate in the healthy behaviors program, and offering opportunities for exercise or physical activity.

The healthy behavior/wellness initiative could be built on initiatives currently offered in the commercial market.

For long term care, greater integration between Medicare and Medicaid services would support wellness and prevention by aligning incentives and coverage to encourage better outcomes rather than fragmented care.

❑ **Sustainability**

How is your proposal sustainable over the long-term? Significant reform of Colorado's current Medicaid program, and the primary, acute, and long term care health systems that support it, is essential to ensure the future viability of any expansion of health care coverage. The reforms to strengthen Medicaid and the overall health care system focus on creating long term savings by improving the care management and health status of Medicaid consumers and on improving management of pharmacy benefits, hospital reimbursement and chronic disease. Similarly, the proposed changes to long term care are designed to position the State to address

the future growth in Colorado's elderly population through more cost-effective home and community based services with enhanced care delivery options, quality management and incentives to promote care in the least restrictive settings.

The efficiencies and savings from the current Medicaid program will create a more sustainable environment for the expansion proposal, including opportunities for targeted, enhanced provider rates. In addition, many of these initiatives would extend efficient and cost-effective practices to the proposed expansion of coverage for the uninsured.

Funding for the proposal would come from a variety of sources, including monies now expended for health care services to the uninsured (unmatched state and local spending and DSH funds), unexpended federal SCHIP allocations, efficiencies/savings in the current Medicaid program, enrollee cost sharing, voluntary employer contributions, savings from leveraging pre-tax contributions to reduce costs, federal funding authorized through a Medicaid s. 1115 waiver and related SPAs.

A partnership of shared responsibility between local entities, the State, the federal government and the private sector, including the business community, labor, providers, advocates and stakeholders, would increase the sustainability of a whole system approach by reducing the number of uninsured, improving the coordination of care for Medicaid recipients and guaranteeing better health and lower health care costs for the overall population.

(Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

Who will pay for any new costs under your proposal? Funding to expand coverage will come from several sources. First, new federal funding will be secured to support a portion of the costs of the expansion through federal approval of Medicaid section 1115 waiver and related state plan amendments. Savings realized from new efficiencies built into the new program to create a more sustainable base will be applied and any unexpended SCHIP funding as well as some portion of current DSH funds will be reallocated to fund a portion of this initiative. Finally, all avenues will be pursued to ensure that the State is taking maximum advantage of all opportunities to claim federal funds.

How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please

explain. Individuals, small business employers and their employees that access coverage through the Exchange would have premiums and cost sharing requirements. Medicaid-funded subsidies would be provided on a sliding scale based on income to make coverage more affordable for low-income uninsured. Small businesses would be eligible to participate in the Exchange (without a subsidy), and could make voluntary contributions towards the cost of insurance for their employees. Government would reallocate a portion of DSH payments from public subsidies for institutions to Medicaid-funded subsidies for the purchase of health insurance for low-income uninsured.

Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain. The new expansion program is voluntary and would leverage Medicaid-funded subsidies to purchase private insurance. No changes are recommended to insurance mandates; the expansion program could access products now available in the market, including “mandate-light” products.

The reform proposal does include recommendations for new Medicaid requirements for quality improvement, care coordination, pay for performance, evidence-based medicine, disease management, wellness and healthy behaviors, reporting and transparency, consumer-directed care, use of information technology, provider training, and pharmacy and hospital management. Some of these quality initiatives would also be incorporated in the guidelines for insurance products for the expansion population.

(Optional) How will your proposal impact cost-shifting? Please explain. The proposal is designed to reduce cost shifting from Medicaid and uncompensated care to other payers.

Are new public funds required for your proposal? Yes, the proposal is designed to maximize the claiming of federal funds, leveraging existing state and local spending. To the extent additional state funding is available, coverage could be expanded to additional uninsured.

(Optional) If your approach requires new public funds, what will be the source of these new funds?

Comprehensive Health Care Reform – Required One-Page Overview

“Designed to expand coverage, increase access to quality care, improve health, and decrease costs broadly for all Coloradans.”

Significantly Expands Access to Coverage. [Recommended initial phase is highlighted in shaded area of the table below.]

- Extends coverage with Medicaid-funded subsidies in the initial phase to more than 490,000 (64%) of low-income uninsured Coloradans.
 - 139,000 children up to 300% FPL
 - 179,000 parents up to 250% FPL
 - 175,000 childless adults up to 225% FPL
- Provides flexibility to extend coverage up to 300% FPL, the maximum allowed under federal Medicaid policy, which could extend coverage up to 73% (561,000) of the uninsured.
- Creates a platform for access to more affordable insurance for uninsured small business, and potentially other uninsured.
- Extends long term care to additional individuals and Veterans.

Colorado	Below 100%		100% to 200%		200% to 250%		250% to 300%		Above 300%		Total
	#	%	#	%	#	%	#	%	#	%	#
Children (0-18)	55,201	7.2%	55,047	7.2%	18,642	2.4%	10,395	1.4%	32,935	4.3%	172,220
Parents	67,290	8.8%	83,346	10.9%	28,957	3.8%	14,698	1.9%	45,845	6.0%	240,136
Childless Adults	74,074	9.7%	80,794	10.5%	40,135*	5.2%	32,066	4.2%	127,240	16.6%	354,309
Total	196,565	25.6%	219,187	28.6%	87,734	11.4%	57,159	7.5%	206,020	26.9%	766,665

Source: U.S. Census Bureau – Current Population Survey – 3 year average – Data collected in 2004 to 2006.

*Assumes approximately half of the childless adults between 200% and 250% FPL have income less than 225% FPL.

Increases Access to Quality Care

- Managed care models that promote and ensure quality.
- Pay-for-performance principles.
- Evidence-based care, quality measures and performance standards.
- Health information technology to reduce errors and improve efficiency.
- Robust reporting and transparency.
- Medical home concept along with ready access to primary care services in a timely manner.
- Consumer-directed care in all models of managed care.
- Disease management programs, including case management for high-cost and complex cases.
- Comprehensive prenatal care case management.
- New long-term care delivery models that integrate care coordination.
- New oversight structures dedicated to quality care improvements.
- Training programs for care providers that address patient safety & privacy, home and community based care.
- Adding specialty pharmacy program with care coordination for specialty drugs, biologics and other injectibles.
- Affordable products, along with premium subsidies and limits on cost sharing for low-income uninsured to encourage enrollment in a health plan and access to primary and preventive care.
- Care coordination in all delivery models.
- Promote wellness and healthy behavior incentives.

Improves Health

- Increased access to health coverage, ready access to primary and preventive care, along with an array of quality measures built into this proposal are designed to improve health and health care outcomes for low-income children, parents, childless adults covered by the expansion and employees of small business eligible to purchase products on the Exchange.
- Coloradans, in general, should benefit as the quality principles built into this proposal are likely to be incorporated in other health insurance plans over time.

Decreases Costs Broadly for All Coloradans

- Health care-related costs should decrease over time as significantly more Coloradans have access to coverage and as Medicaid implements cost-containment and care coordination strategies.
- Costs for long term care will also decline as the elderly and persons with disabilities benefit from high quality, consumer-directed care delivered in a cost-effective manner in the least restrictive and clinically appropriate setting.